SERFF Tracking Number:	*UHLC-125939264*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41080*
Company Tracking Number:			
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.001 Home Health Care*
Product Name:	*UHIC Short Term Care*		
Project Name/Number:	*UHIC Short Term Care/*		

Filing at a Glance

Company: United HealthCare Insurance Company

Product Name: UHIC Short Term Care	SERFF Tr Num: UHLC-125939264	State: ArkansasLH
TOI: H13I Individual Health - Short Term Care	SERFF Status: Closed	State Tr Num: 41080
Sub-TOI: H13I.001 Home Health Care	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Marie Bennett
	Authors: Judith Davenport, Martha Blanke, Becky Kieran	Disposition Date: 02/19/2009
	Date Submitted: 12/10/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: UHIC Short Term Care	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 08/25/2008
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 02/19/2009	Explanation for Other Group Market Type:
	State Status Changed: 02/19/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

We enclose for filing, copies of United’s individual short term care insurance policy and associated forms, actuarial memorandum and rates. The enclosed policy is a guaranteed renewable short term care insurance policy.

The forms are new and will not replace any form currently on file with your Department. The policy will be sold either through brokers, direct telephone sales or Direct Mail.

SERFF Tracking Number:	*UHLC-125939264*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41080*
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Coverage under the policy consists of Home Health Care, Adult Day Care and Respite Care Benefits. Benefits are payable for the charges incurred, up to a chosen maximum daily benefit. Limited expenses are also payable for Caregiver Training and Home Modification.

Benefits are not subject to a Lifetime Waiting Period (0 days). The policy offers three lifetime maximum benefit amount choices (6 months, 9 months or 12 months). The lifetime maximum benefit is based on a “pool of money” approach.

An automatic inflation increase is built in the base policy which increases benefits at a rate of 5% compounded annually. Increases occur annually on the policy anniversary for as long as the policy remains in force.

The forms have been filed in the Company’s domicile state of Connecticut and were Approved on August 25, 2008.

We respectfully request your favorable consideration and approval of this filing.

Company and Contact

Filing Contact Information

Judith Davenport, Manager
5995 Plaza Dr.
Cypress, CA 90630

judy.davenport@phs.com
(714) 226-3507 [Phone]
(714) 226-3238[FAX]

Filing Company Information

United HealthCare Insurance Company
450 Columbus Boulevard
PO Box 150450
Hartford, CT 06115-0450
(215) 653-8046 ext. [Phone]

CoCode: 79413
Group Code: 707

Group Name:
FEIN Number: 36-2739571

State of Domicile: Connecticut
Company Type: Health

State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	$50.00 for policy and associated forms and $50.00 for the rate information filing.

SERFF Tracking Number:	*UHLC-125939264*	*State:*	*Arkansas*
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Per Company: No

SERFF Tracking Number:	*UHLC-125939264*	*State:*	*Arkansas*
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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United HealthCare Insurance Company	$100.00	12/10/2008	24451076

SERFF Tracking Number:	*UHLC-125939264*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Marie Bennett	02/19/2009	02/19/2009

SERFF Tracking Number:	*UHLC-125939264*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41080*
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Project Name/Number:	*UHIC Short Term Care/*		

Disposition

Disposition Date: 02/19/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-125939264*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41080*
Company Tracking Number:			
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Project Name/Number:	*UHIC Short Term Care/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		Yes
Form	Short Term Care Insurance Policy		Yes
Form	Short Term Care Insurance Outline of Coverage		Yes
Form	Notice		Yes
Form	Application		Yes
Form	Application		Yes

SERFF Tracking Number:	*UHLC-125939264*	*State:*	*Arkansas*
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Company Tracking Number:			
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Form Schedule

Lead Form Number: STC POL 1000

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	STC POL 1000	Policy/Contract/Fraternal Certificate	Short Term Care Insurance Policy	Initial		41	STC POL 1000.pdf
	STC OC 1000	Outline of Coverage	Short Term Care Insurance Outline of Coverage	Initial			STC OC 1000.pdf
	STC NOTICE AR	Other	Notice	Initial			STC NOTICE AR.pdf
	STC APP 1000	Application/Enrollment Form	Application	Initial			STC APP 1000.pdf
	STC APPSU 1000	Application/Enrollment Form	Application	Initial			STC APPSU 1000.pdf

United HealthCare Insurance Company

Home Office: [450 Columbus Boulevard, Hartford, CT 06115]

Administrative Office: [P.O. Box 541203, Waltham, MA 02453-1203, 877-272-3959]

Short Term Care Insurance Policy

THIS POLICY PROVIDES BENEFITS FOR HOME AND COMMUNITY CARE ONLY. PLEASE READ IT CAREFULLY.

United HealthCare Insurance Company (UHIC) will provide the benefits described in this Policy to the insured Policyholder (referred to as You, Your, and Yours) in acceptance of the application and premium, and subject to all Policy provisions.

In this Policy, "We", "Our", and "Us" are used to refer to United HealthCare Insurance Company.

The Policy becomes effective at 12:00 a.m. Standard Time on the "Effective Date" shown on the "Policy Information Page."

Right To Renew. This Policy is Guaranteed Renewable. This means You have the right, subject to the terms of the Policy, to continue this Policy as long as You pay Your premiums on time.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from UHIC.

CAUTION. This Policy was issued based on Your answers to the questions on Your application and payment of the first premium. A copy of Your application is attached. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If for any reason, any of Your answers are incorrect, please contact Us at [P.O. Box 541203, Waltham, MA 02453-1203].

Thirty Day Right To Examine Policy. If You are not satisfied for any reason, You may return Your Policy within thirty (30) days after receipt. The premium will be refunded, less any claims paid during this period. When so returned, the Policy is void from the beginning. Return the Policy to Us at [Administrative Office: P.O. Box 541203, Waltham, MA 02453-1203].

The Policy is delivered in and governed by the laws of the State of [***state name***].

Please Read Your Insurance Policy Carefully. It is a legal contract between You and Us.

United HealthCare Insurance Company

[President]

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Table of Contents

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POLICY INFORMATION PAGE

POLICYHOLDER: [John Doe]
POLICY NUMBER: [UHCXXX]
PLAN NAME: [Short Term Care]
ORIGINAL EFFECTIVE DATE: [January 1, 2008]
POLICY ANNIVERSARY: [January 1, 2008]
PREMIUM MODE: [Monthly][Quarterly][Semiannual][Annual]
LIFETIME LEVEL MODAL PREMIUM*: [$XXXX.XX]
AUTOMATIC INFLATION INCREASES: Yes

Schedule of Benefits

Waiting Period	[0 days]
Benefit Period	[XX-XXX] days
Maximum Lifetime Benefit	[$XX,XXX]
Maximum Daily Benefit Home and Community Benefits *Home Health Care Services* *Adult Day Care* *Homemaker Services* *Hospice Care*	[$XX-$XXX] per day
Additional Benefits Caregiver Training Benefit Home Modification Benefit Respite Care Benefit	 [$500] Lifetime Benefit [$1,500] Lifetime Benefit [21] days per Calendar Year

*An additional cost has been included if You pay premiums more frequently than annually.

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Section I

Definitions

When used in this Policy the following words and phrases have the meaning given.

Activities of Daily Living (ADL) include the following functions and are used as one measure to determine Your eligibility for benefits:

(a) Bathing: washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower;

(b) Continence: ability to maintain control of bowel and bladder function or, when not able to maintain control of bowel or bladder function, the ability to perform related personal hygiene (including caring for catheter or colostomy bag);

(c) Dressing: putting on and taking off all items of clothing and any required braces, fasteners, or artificial limbs;

(d) Eating: feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously;

(e) Toileting: getting to and from the toilet, getting on and off the toilet, and performing related personal hygiene;

(f) Transferring: moving into or out of a bed, chair or wheelchair.

Adult Day Care means a program of social and health-related services for six (6) or more individuals, which is provided during the day in an Adult Day Care Center for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the Home. It does not include twenty-four (24) hour care. It does not include care provided by a family member related by blood or marriage.

Adult Day Care Center means a place that is licensed to provide Adult Day Care in accordance with state laws in which preventive, remedial, and restorative services are provided in a protective environment for part of the twenty-four (24) hour day. If licensing is not required, Adult Day Care Center means a place that:

1. provides Adult Day Care; and
2. maintains a daily written record of each client who receives services; and
3. has a staff including, at least, a director, one full-time registered professional Nurse, licensed vocational Nurse or licensed practical Nurse, and enough full-time staff to maintain no more than an eight (8) to one (1) client-staff ratio; and
4. has established procedures for obtaining appropriate aid in the event of a medical emergency.

Assisted Living Facility means an institution that is licensed by the appropriate federal or state agency to engage primarily in providing care and unscheduled services to at least six (6) resident inpatients in one location and meets all of the following criteria:

1. provides twenty-four (24) hour-a-day care and services sufficient to support the needs of a Chronically Ill individual; and
2. has a trained and ready to respond employee on duty at all times to provide that care and service; and
3. provides three (3) meals a day and accommodates special dietary needs; and
4. has arrangements with a Physician or nurse to furnish medical care in the case of an emergency; and
5. has the appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

If an institution (such as a congregate care facility or life care community) has multiple licenses or multiple purposes, only the portion, ward, wing or unit (including a separate room or apartment) that specifically provides the above described care and meets all of the above requirements will be defined as an Assisted Living Facility.

Benefit Period means the number of days elected on the application by the Policyholder used to calculate the Maximum Lifetime Benefit.

Calendar Year means the period of time from January 1st through December 31st.

Care Advisor means the person appointed by Us who, either alone or as part of a team, is responsible for performing assessments and reassessments, developing Plans of Care, coordinating the provision of care, and monitoring the delivery of services to suit Your specific care needs. Care Advisors are familiar with the Care Providers available in the area. Care Advisors will help identify qualified caregivers that are acceptable to You and Your family. In all cases, You are responsible for choosing the actual Care Providers to be used. If for any reason You are not satisfied with a Care Provider, You may request that the Care Advisor identify other Care Providers from which to choose.

Caregiver Training means expenses You incur for training an unpaid caregiver to care for You in Your Home. The person receiving the training can be a relative or someone else chosen by You, but in no event will We pay for training provided to someone who will be paid to care for You. The training cannot be received while You are confined in a Hospital unless it is reasonably expected that the training will make it possible for You to go Home where You can be cared for by the person receiving the training.

Care Provider means a Home Health Aide, Homemaker, Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline provided through a licensed Home Health Care Agency, an Adult Day Care Center or a Hospice, or referred by a licensed referral agency or licensed nurses' registry.

Class means a population segment with the same or similar Policy characteristics such as issue year, zip code, issue age, underwriting and rating classification, selected benefit options, or Waiting Period.

Cognitive Impairment means a loss or deterioration in intellectual capacity that requires Substantial Supervision to protect You from threats to health and safety. Cognitive Impairment is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the person's: (i)short-term or long-term memory; (ii)orientation as to people, places or time; and (iii) deductive or abstract reasoning.

Covered Short Term Care means services for Nursing Care, Home Health Care, Adult Day Care or Hospice Care, which are required by a Cognitively or Functionally Impaired individual and are provided in Your Home pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner in coordination with a Care Advisor.

Custodial Care means services provided on an extended basis to a Cognitively or Functionally Impaired individual that are intended to maintain a person's health and/or functional status. Custodial Care does not include any transportation or other service which is chiefly for personal convenience or companionship.

Family Member means Your spouse and anyone who is related to You or Your spouse (including adopted, in-law and step-relatives) such as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.

Functional Impairment means the inability to perform at least two Activities of Daily Living without Substantial Assistance of another person and without the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL.

Home means Your primary place of residence used principally for independent residential living. This could be a house, a condominium, an apartment, a unit in a congregate care community, or similar residential environment. Home does not include a Hospital, Nursing Facility, or Assisted Living Facility.

Home Health Aide means a person whose main function is to provide personal care services. If state and local licensing or certification is required, the person must be licensed or certified as a Home Health Aide where the service is performed.

Home Health Care means medical and non-medical services provided to ill, disabled or infirm persons in their Home. These services may include Nursing Care, assistance with Activities of Daily Living, Homemaker services, Respite Care services and Hospice care. These services must be provided by a Care Provider through a licensed Home Health Care Agency or referred by a licensed referral agency or licensed nurses' registry.

Home Health Care Agency means an organization licensed or certified as a Home Health Care Agency under the laws where it is located, under a public health law or similar law, if licensing or certification is required, to provide Home Health Care services.

Homemaker means a skilled or unskilled person who performs maintenance services that are necessary for or consistent with Your ability to stay in Your Home. These activities may include, but are not limited to, preparing meals, laundry, and light housekeeping.

Hospice means a private agency or unit of a public or private agency that meets federal certification requirements as a Hospice, or is comparably licensed under the laws where it is located, to provide care or management to individuals that are Terminally Ill.

Hospital means an acute care facility defined and operated pursuant to state laws.

Licensed Health Care Practitioner means any Physician (as defined in section 1861(r)(l) of the Social Security Act), any registered professional Nurse, any licensed social worker or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

Maximum Daily Benefit means the greatest amount that We will pay for all expenses combined that You incur on any one day under all benefits available under this Policy. An expense is considered to be incurred on the day on which the care or service is received.

Maximum Lifetime Benefit means the amount that results by multiplying the Maximum Daily Benefit by the number of Benefit Period days that has been elected by the Policyholder.

Medicare means the Health Insurance for Aged Act, Title XVIII of the Social Security Act Amendments of 1965, as Constituted and Later Amended.

Mental or Nervous Disorder means a condition of neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

Nurse means Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.).

Nursing Care means Nursing Care Services requiring the professional skills of a Nurse under the orders of a Physician that improve or maintain Your health.

Nursing Care Services mean services furnished pursuant to a Physician's orders which require the skills of technical or professional personnel, such as a Nurse, physical therapist, occupational therapist, speech pathologist, audiologist or similar discipline; and are provided directly by or under the supervision of such personnel.

Nursing Facility means a facility that is engaged primarily in providing continual (24 hours-a-day, every day) Nursing Care to its residents or inpatients in accordance with the authority granted by a license issued by the federal government or the state in which it is located. Such Nursing Care must be performed by or under the direct supervision of a Nurse. The facility must employ at least one full-time (at least 30 hours per week) Nurse. A Nurse must be on duty or on call in the facility at all times.

If a facility has multiple licenses or purposes, a separate portion, ward, wing or unit thereof will be defined as a Nursing Facility only if that portion, ward, wing or unit is engaged primarily in providing such Nursing Care in accordance with the authority granted by its license.

The definition of a Nursing Facility does NOT include any of the following:

1. a clinic or Hospital;
2. a sub-acute care or rehabilitation hospital or unit;

3. a place that operates primarily for the treatment of alcoholism, drug addiction, or mental illness;
4. an Assisted Living Facility;
5. the Policyholder's Home or place of residence in an area used principally for independent residential living (including, but not limited to, hotels, motels, retirement homes, boarding homes and adult foster care facilities);
6. an adult residence establishment or environment which is similar to the above listed places; or
7. any facility that is located outside of the United States, its territories and possessions.

Physician means a Physician as defined in section 1861(r)(1) of the Social Security Act, as amended. It is a licensed doctor practicing within the scope of his/her license and rendering care and treatment that is appropriate for Your condition and locality. The term does not include Your spouse or Your immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in Your household.

Plan of Care means a written description of Your needs that fairly, accurately and appropriately addresses Your need for Covered Short Term Care services. The Plan of Care must specify the type, frequency (including duration), and type of Care Providers required by You.

Policy means this legal contract, including the application, and any riders or endorsements issued to the Policyholder providing the benefits described herein.

Respite Care means Nursing Care, Custodial Care or Hospice Care provided to You in Your Home that allows family or volunteer caregivers temporary relief.

Substantial Assistance means the support of another person who must provide physical hands-on assistance or who must be within arm's reach of You to prevent, by physical intervention if necessary, injury while You perform an Activity of Daily Living.

Substantial Supervision means continual supervision which may include cuing by verbal prompting, gestures, or other demonstrations by another person that is necessary to protect You from harming Yourself or others when You have a Cognitive Impairment.

Terminally Ill means an illness or injury, as certified by a Physician that results in a person's death within six (6) months of the diagnosis.

Waiting Period means the number of days after the Policy Effective Date during which You are: (1) Cognitively or Functionally Impaired; and (2) receiving paid Covered Short Term Care services before You can receive benefits.

Section II

Eligibility

Benefit Eligibility

To be eligible for benefits provided by this Policy, a Licensed Health Care Practitioner must certify You as having a Cognitive or Functional Impairment pursuant to a Plan of Care.

Eligibility for the Payment of Benefits

Benefits are payable only for Covered Short Term Care services. All benefits are subject to Your Maximum Lifetime Benefit. Certain benefits are subject to Your Maximum Daily Benefit.

Section III

Benefits

Home and Community Benefits

We will pay 100% of the expenses You incur for Nursing Care Services, Home Health Care Services, Adult Day Care, or Hospice Care rendered in Your Home up to Your Maximum Daily Benefit and Maximum Lifetime Benefit subject to the Waiting Period as shown on the Schedule Page.

Alternative Plan of Care Benefit

We may pay for alternative benefits under this provision for Covered Short Term Care services that are medically acceptable, cost effective and agreed to by You, Us and Your Physician up to Your Maximum Daily Benefit and Your Maximum Lifetime Benefit.

You maintain the right to discontinue the Alternative Plan of Care Benefit and resume receiving benefits as defined in this Policy.

Caregiver Training Benefit

We will pay 100% of the expenses You incur for Caregiver Training received by an informal (unpaid) caregiver for up to the Caregiver Training Lifetime Benefit as shown on the Schedule Page. This benefit is not subject to Your Maximum Daily Benefit, but it is subject to Your Maximum Lifetime Benefit.

Home Modification Benefit

We will pay 100% of the expenses You incur for: (a) structural modification to Your Home that will allow You to remain in Your Home, or (b) medical equipment designed and used to treat a sickness or injury for up to the Home Modification Lifetime Benefit as shown on the

Schedule Page. This benefit is not subject to Your Maximum Daily Benefit, but it is subject to Your Maximum Lifetime Benefit.

Respite Care Benefit

We will pay 100% of the expenses You incur for each day You receive Respite Care provided at Home as shown on the Schedule Page up to Your Maximum Daily Benefit and Your Maximum Lifetime Benefit.

Automatic Inflation Increases

As protection against inflation, the Maximum Daily Benefit amount will be increased by five percent (5%) compounded annually on each Policy Anniversary date. Any time Your Maximum Daily Benefit amount changes under this section, the Maximum Lifetime Benefit will be increased by five percent (5%) of the Remaining Lifetime Benefit. The Remaining Lifetime Benefit on the current Policy Anniversary is the Maximum Lifetime Benefit on the previous Policy Anniversary less the total of all claims paid up to the current Policy Anniversary.

Inflation increases are made without regard to Your age, claim status, claim history or the length of time Your Policy has been inforce. Your Premium will not increase for each increase in benefits under this section.

Section IV

Exclusions and Limitations

We will not pay benefits for any care services that are:

1. Services for which benefits are payable under Medicare or other governmental programs, except Medicaid; any state or federal workers' compensation, employer's liability or occupational disease law; a motor vehicle no-fault law;

2. Mental or Nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

3. Provided in a government facility, Nursing Facility, Assisted Living Facility or Hospital;

4. Services provided by family members unless: (a) he or she is a regular employee of a Home Health Care Agency; (b) the Home Health Care Agency receives payment for the services; and (c) he or she receives no compensation other than the normal compensation for employees of that Home Health Care Agency;

5. Illness or medical condition arising out of war or any act of war, declared or undeclared while serving in the military service or any auxiliary unit attached thereto;

6. Services for attempted suicide or intentionally self-inflicted injury;

7. Services received outside the United States and its possessions;

8. Services and supplies not in the Plan of Care;

9. Alcoholism, drug addiction, or chemical dependency unless as a result of medication as prescribed by a Physician; and

10. Services for which no charge is normally made in the absence of insurance.

Section V

Premium Provisions

Premiums

We provide insurance coverage in return for premium payment. The first premium is due on the Effective Date. Future premiums are due on or before each Premium Due Date in order for insurance to remain in effect.

Premium Changes. This Policy is guaranteed renewable. We will not change Your premiums because of age or health. We may, however, change Your premiums on a class basis, subject to applicable state insurance department approval, but only if We change the premiums for all Policyholders in the same class.

If We elect to change premium rates, Your premium will change on the first Premium Due Date following:

1. The effective date of the change stated in Our written notice to You; or

2. The date any of the Policy's terms are changed, including changes due to any federal or state law or regulation affecting Our liability under the Policy.

We will notify You of any premium change at least forty-five (45) days before the Premium Due Date on which Your premiums change.

Refund of Unearned Premium. We will make a pro-rata refund of premium paid for the period beyond the date of cancellation or death of the Policyholder. We will pay the refund directly to You or Your estate.

Grace Period. You have a thirty-one (31) day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. It will terminate at the end of the grace period if all premiums due are not paid, unless non-payment is due to a clerical error made by You or by Us.

Unintentional Lapse. In addition to Yourself, You have a right to designate another individual to receive notification of lapse or termination. If the premium is not paid by the end of the grace period, We will inform both You and, if chosen, the designated individual at least thirty-one (31) days before the effective date of lapse. The notice will be given by first class United States mail,

postage prepaid, to You and to the designated individual. Notice is considered to have been given as of five (5) days after the date of mailing.

Unpaid Premium. When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

Waiver of Premium During Benefit Period. UHIC will keep Your Policy in force and waive the payment of premiums for it during the Premium Waiver Period described below if it has been determined by Our Care Advisor that You meet the eligibility requirements for receipt of benefits.

Premiums will be waived on a month-by-month basis.

If premiums are being paid other than monthly, You will be placed on the monthly premium payment mode when We start to waive premiums. We will then refund any unearned monthly premiums, starting with the premium of the first full month for which premiums are waived.

Premium Waiver Period. The Premium Waiver Period begins the first day of the month following the day benefits become payable.

The Premium Waiver Period will end on the earliest of the following dates:
1. The date You no longer meet the eligibility requirements for benefits; or
2. The date You have exhausted the Maximum Lifetime Benefit payable under the Policy.

When the Premium Waiver Period ends, and if You have not exhausted the Maximum Lifetime Benefit amount payable under the Policy, Your coverage may be continued in force by payment of the first premium due after the date the Premium Waiver Period ends. The premium will be the same as in effect prior to the date the waiver of premium started, subject to any change in the premium rates which may have occurred as provided in the Premium Provisions.

Reinstatement of Coverage. If Your coverage terminates for non-payment of premium, coverage may be reinstated at Our option. You may request reinstatement up to six (6) months after termination of Your Policy.

We may require You to submit an application for reinstatement. If We require an application for reinstatement and issue a conditional receipt for the accepted premium, Your Policy will be reinstated upon approval of Your application for reinstatement; or, lacking such approval, Your Policy will be reinstated no later than forty-five (45) days following the date of such conditional receipt, unless We have notified You in writing of the disapproval of Your application for reinstatement.

If We do not require an application for reinstatement, coverage will be reinstated as of the date We accept Your premium.

You must pay the premium due retroactively to the date Your Policy terminated.

The reinstated coverage will only apply to benefits that are provided after the date of reinstatement.

Section VI

When You Have A Claim

Notice of Claim. We must be given notice of claim within thirty (30) days after a covered loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain Your name and enough information to identify You, and an address to which the claim form(s) should be sent. Notice may be mailed to [Administrative Office: P.O. Box 541203, Waltham, MA 02453-1203]. Notice may also be made by calling [800-xxx-xxxx].

Claim Forms. When We receive notice of claim, We will provide You with claim form(s) within fifteen (15) days after We receive notice. If We do not provide You with claim forms within fifteen (15) days after We receive Your notice of claim, You will be deemed to have complied with Our claim form requirements if, within the time fixed in the Policy for filing of Proof of Loss, You provide Us with written proof of the date(s) and exact nature of the charges You have incurred.

Proof of Loss. Written proof must be sent to Us within ninety (90) days after the date the loss occurs. If it was not reasonably possible to give Us written proof within ninety (90) days, We will not reduce or deny a claim for this reason, if proof is filed as soon as reasonably possible, and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

Time of Payment of Claim. After We receive the proper written Proof of Loss, benefits will be paid immediately. Benefits will be paid monthly when the loss is expected to result in ongoing benefits. Benefits will be paid immediately when Our liability has ended.

Payment of Claims. All benefits are paid to You or to Your estate. If You have signed an assignment of benefits, Your benefits will be paid directly to the Care Provider. Any payment We make in good faith will fully release Us of Our responsibility to the extent of the payment.

Physical Examination. At Our expense, We may require You to undergo a physical examination when reasonably required while a claim is pending.

Extension of Benefits. If Your Policy lapses while benefits are payable for Covered Short Term Care services, it will not affect a claim beginning before the lapse. We will continue to pay benefits for Covered Short Term Care services beyond the date of the lapse for as long as You remain benefit eligible without interruption.

This Extension of Benefits is subject to Your Maximum Lifetime Benefit and all other Policy provisions.

Section VII

Appealing a Decision

You and the Company may not always agree that a claim or request for services has been reviewed properly. When this happens, You are encouraged to write to Our Customer Service Department at [United HealthCare Insurance Company, LTC Administration, P.O. Box 541203, Waltham, MA 02453].

If You disagree with a claim determination because We have partially or fully denied benefits, You may file an appeal and request that We review Our decision. The request must be sent to Us in writing, and must include Your reason for the request and any documents that You feel are pertinent to Your situation. The request should be sent to Us within sixty (60) business days after You receive Our denial.

You may designate a representative to file an appeal on Your behalf by providing written notice that includes the issue in dispute, Your signature and the representative's signature.

We will review Your request and notify You or Your representative of Our decision within ninety (90) business days of receiving the request. If a longer investigation period is required, We will notify You of the reason why and when a decision may be expected. In such case, We will provide a written decision within one hundred twenty (120) days of receiving the request.

For determinations that the services are not Covered Services, the response will specify the provisions in the Policy that exclude that coverage.

Section VIII

General Provisions

Conformity to State and Federal Law. We amend any provision of the Policy that conflicts with state or federal law on the Policy Effective Date to the minimum requirements of the law.

Entire Contract; Changes. This Policy together with the Application, endorsements and riders, if any, make up the entire contract of insurance. No change in the Policy shall be valid unless approved in writing by one of Our officers. Any change must be noted on or attached hereto. No agent may change this Policy or waive any of its provisions.

Legal Actions. No legal action may be brought to recover against the Policy within sixty (60) days after written proof of loss has been given. No such action will be brought after three (3) years from the time written proof of loss is required to be given. If a time limit of the Policy is less than allowed by the laws of the state where You live, the limit is extended to meet the minimum time allowed by such law.

Right to Receive Information. The Policyholder shall provide Us with the information necessary to administer coverage under the Policy.

Right of Recovery. If payment of claims exceeds the maximum amount payable under any benefit provisions or riders of the Policy, We have the right to recover the excess of such payments.

Misstatement of Age. If Your age was misstated on Your application, Your Policy premium or amounts of coverage will be changed to correspond to Your correct age at the date this Policy was issued.

Time Limit on Certain Defenses. We have issued this Policy based on the information You provided in the application. Any misrepresentations known to You at the time of the application may cause Your Policy to be voided or rescinded, or a claim to be denied.

After this Policy has been in force for a period of two (2) years during Your lifetime, this Policy shall become incontestable, except for non payment of premium, as to a misstatement made in the application, unless that misstatement was fraudulent.

Waiver of Rights. Our failure to enforce any provision of the Policy does not affect Our right to enforce any provision at a later date, and does not affect Our right to enforce any other provision of the Policy.

Portability. This Policy recognizes Covered Short Term Care services provided to You anywhere in the United States by Providers duly licensed or certified in accordance with applicable state or federal law.

Section IX

When Coverage Ends

Your insurance ends on the earliest of:

1. The date You cancel or do not renew the Policy; or
2. On the expiration of the grace period, if the required premium is not paid, unless premium is being waived; or
3. The date We discover any false representations or concealment of material facts upon enrollment; or
4. The date the Lifetime Benefit Maximum has been exhausted; or
5. The date of Your death.

UNITED HEALTHCARE INSURANCE COMPANY (UHIC)
Home Office: [450 Columbus Boulevard, Hartford, CT 06115]

Administrative Office: [P.O. Box 541203, Waltham, MA 02453-1203, 877-272-3959]

SHORT TERM CARE INSURANCE
OUTLINE OF COVERAGE

[STC POL 1000]

Caution: The issuance of the policy is based upon your responses to the questions on the application. A copy of the application will be enclosed with the policy. If your answers are incorrect or untrue, we have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the address or toll-free telephone number listed above.

Notice to Buyer: The policy may not cover all of the costs associated with short term care, which may be incurred by you during the period of coverage. It provides coverage for home and community care only. You are advised to periodically review the policy in relation to the changes in the cost of short term care. The policy is subject to certain coverage limitations and exclusions. You are advised to carefully review all limitations and exclusions.

1. The policy is an individual policy.

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual policy contains governing contractual provisions. This means that the policy sets forth in detail your rights and obligations and our rights and obligations. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ THE POLICY CAREFULLY!

3. TERMS UNDER WHICH THE CONTRACT MAY BE RETURNED AND PREMIUM REFUNDED.

   (a) Thirty Day Right to Examine Policy: If you are not satisfied for any reason, you may return your policy within thirty (30) days after receipt. The premium will be refunded, less any claims paid during this period. When so returned, the policy is void from the beginning. Return the policy to us at [Administrative Office: P.O. Box 541203, Waltham, MA 02453-1203].

   (b) Return of Unearned Premium: We will make a pro-rata refund of premium paid for the period beyond the date of your cancellation or death. We will pay the refund directly to you or your estate.

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from UHIC.

   Neither the UHIC nor its agents represent Medicare, the federal government or any state government.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS**.** The policy is guaranteed renewable. We will not change your premiums because of age or health. We may, however, change your premiums on a class basis, subject to applicable state insurance department approval, but only if we change the premiums for all policyholders in the same class. We will notify you of any premium change at least [forty-five (45)] days before the premium due date on which your premiums change.

6. SHORT TERM CARE COVERAGE. Policies of this category are designed to provide limited coverage. The policy provides coverage on an expense incurred basis for Short Term Care Services, subject to the Maximum Daily Benefit, the Maximum Lifetime Benefit, the Lifetime Waiting Period and all policy provisions.

7. BENEFITS PROVIDED BY THE POLICY.

   Benefit Eligibility: To be eligible for benefits provided by this policy, a Licensed Health Care Practitioner must certify you as having a Cognitive or Functional Impairment pursuant to a Plan of Care.

   Eligibility for the Payment of Benefits: Benefits are payable only for Covered Short Term Care services. All benefits are subject to your Maximum Lifetime Benefit. Certain benefits are subject to your Maximum Daily Benefit.

   Home and Community Benefits
   We will pay 100% of the expenses you incur for Nursing Care Services, Home Health Care Services, Adult Day Care, or Hospice Care rendered in your home up to your Maximum Daily Benefit and Maximum Lifetime Benefit subject to the Waiting Period.

   Alternative Plan of Care Benefit
   We may pay for alternative benefits under this provision for Covered Short Term Care services that are medically acceptable, cost effective and agreed to by you, us and your Physician up to your Maximum Daily Benefit and your Maximum Lifetime Benefit.

   You maintain the right to discontinue the Alternative Plan of Care Benefit and resume receiving benefits as defined in the policy.

   Caregiver Training Benefit
   We will pay one hundred percent (100%) of the expenses you incur for Caregiver Training received by an informal (unpaid) caregiver for up to the Caregiver Training Lifetime Benefit. This benefit is not subject to the Maximum Daily Benefit, but it is subject to the Maximum Lifetime Benefit.

Home Modification Benefit
We will pay one hundred percent (100%) of the expenses you incur for: (a) structural modification to your home that will allow you to remain in your home; or (b) medical equipment designed and used to treat a sickness or injury for up to the Home Modification Lifetime Benefit. This benefit is not subject to the Maximum Daily Benefit, but it is subject to the Maximum Lifetime Benefit.

Respite Care Benefit
We will pay one hundred percent (100%) of the expenses you incur for each day you receive Respite Care provided at home for up to twenty-one (21)] days per calendar year up to the Maximum Daily Benefit and Maximum Lifetime Benefit.

Important Terms:

1. Activities of Daily Living include the following functions and are used as one measure to determine your eligibility for benefits:
   (a) Bathing: washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower;
   (b) Continence: ability to maintain control of bowel and bladder function or, when not able to maintain control of bowel or bladder function, the ability to perform related personal hygiene (including caring for catheter or colostomy bag);
   (c) Dressing: putting on and taking off all items of clothing and any required braces, fasteners, or artificial limbs;
   (d) Eating: feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously;
   (e) Toileting: getting to and from the toilet, getting on and off the toilet, and performing related personal hygiene;
   (f) Transferring: moving into or out of a bed, chair or wheelchair.

2. Cognitive Impairment means a loss or deterioration in intellectual capacity that requires Substantial Supervision to protect you from threats to health and safety. Cognitive Impairment is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the person's: (i) short-term or long-term memory; (ii) orientation as to people, places or time; and (iii) deductive or abstract reasoning.

3. Covered Short Term Care means services for Nursing Care, Home Health Care, Adult Day Care or Hospice Care, which are required by a Cognitively or Functionally Impaired individual and are provided in your home pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner in coordination with a Care Advisor.

4. Functional Impairment means the inability to perform at least two Activities of Daily Living without Substantial Assistance of another person and without the presence of another person within arm's reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL.

5. Maximum Daily Benefit means the greatest amount that we will pay for all expenses combined that you incur on any one day under all benefits available under the policy. An expense is considered to be incurred on the day on which the care or service is received.

6. Maximum Lifetime Benefit means the amount that result by multiplying the Maximum Daily Benefit by the number of Benefit Period days that has been elected by the policyholder.

8. LIMITATIONS AND EXCLUSIONS.

(a) There are no pre-existing condition limitations for the policy;

(b) The policy will not pay benefits for any care services that are:

- Services for which benefits are payable under Medicare or other governmental program, except Medicaid; any state or Federal workers' compensation, employer's liability or occupational disease law; a motor vehicle no-fault law;
- Mental or Nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;
- Treatment provided in a government facility, Nursing Facility, Assisted Living Facility or Hospital;
- Services provided by family members unless: (a) he or she is a regular employee of a home health care agency; (b) the home health care agency receives payment for the services; and (c) he or she receives no compensation other than the normal compensation for employees of that home health care agency;
- Illness or medical condition arising out of war or any act of war, declared or undeclared while serving in the military service or any auxiliary unit attached thereto;
- Services for attempted suicide or intentionally self-inflicted injury;
- Services received outside the United States and its possessions;
- Services and supplies not in the Plan of Care;
- Alcoholism, drug addiction, or chemical dependency unless as a result of medication as prescribed by a Physician ; and
- Services for which no charge is normally made in the absence of insurance.

THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR SHORT TERM CARE NEEDS.

9. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of short term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted.

The policy includes an Automatic Inflation Increases provision. The Maximum Daily Benefit amount will be increased by five percent (5%) compounded annually on each Policy Anniversary date. Any time the Maximum Daily Benefit amount changes under this section, the Maximum Lifetime Benefit will be increased by five percent (5%) of the Remaining Lifetime Benefit. The Remaining Lifetime Benefit on the current Policy Anniversary is the Maximum Lifetime Benefit on the previous Policy Anniversary less the total of all claims paid up to the current Policy Anniversary.

10. TERMS UNDER WHICH THE CONTRACT MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. UnitedHealthcare Insurance Company cannot change any of the terms of your policy on its own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY.

(b) Waiver of Premium: The premium waiver period begins the first day of the month following the day benefits become payable. When the premium waiver period ends, and if you have not exhausted the Maximum Lifetime Benefit amount payable under the policy, your coverage may be continued in force by payment of the first premium due after the date the premium waiver period ends.

11. PREMIUM.

Short Term Care Insurance Policy	$_____
Marital Discount, if applicable	$_____
Total Annual Premium	$_____

The amount of premium for the policy is dependent upon your selections of Maximum Daily Benefit and Maximum Lifetime Benefit.

12. ADDITIONAL FEATURES.

(a) Medical Underwriting: The policy will be issued based on your answers to the questions on the application and any additional information that may be needed to complete the evaluation process.

(b) Unintentional Lapse: In addition to yourself, you have a right to designate another individual to receive notification of lapse or termination. If the premium is not paid by the end of the grace period, we will inform both you and, if chosen, the designated individual at least thirty-one (31) days before the effective date of lapse. The notice will be given by first class United States mail, postage prepaid, to you and to the designated individual. Notice is considered to have been given as of five (5) days after the date of mailing.

NOTICE

Your United HealthCare Insurance Company representative will be happy to help You with any question or problem relating to Your Policy. You can also contact Us with any question at:

1-877-272-3959

If You prefer, You can write to Us at the address shown below. Please include Your full name, address and policy number with all correspondence.

Attn: Administrative Office
[P.O. Box 541203
Waltham, MA 02453-1203]

If You feel that We have not fully handled Your request, You may call or write to the Arkansas Insurance Department.

Attn: Consumer Service Division
1200 West Third Street
Little Rock, AR 72201-1904
1-800-852-5494
or
1-501-371-2640

Before You contact the Insurance Department, first contact United HealthCare Insurance Company and let Us assist You directly.

Your Agent (if applicable):

Name:_____

Phone:_____

STEP 1: Find out if you are eligible to apply

FOR APPLICANT **1**

This step determines your eligibility for coverage under the United HealthCare Insurance Company (UnitedHealthcare) Short-Term Care policy, so please answer all of the questions on this page before completing any other part of this application.

1. Do you currently:

○ Yes	○ No	Use or require the use of any mechanical or medical devices such as a wheelchair, walker, multi-prong cane, crutches, hospital bed, dialysis, respirator oxygen, motorized cart or stair lift?
○ Yes	○ No	Need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, transferring or maintaining continence?
○ Yes	○ No	Need help, assistance or supervision in performing two or more of the following everyday activities: taking medication, doing housework, laundry, shopping or meal preparation?

2. ○ Yes ○ No Within the past two years, has a person or institution acted on your behalf due to any mental or physical disability?

3. Have you ever experienced symptoms of, been diagnosed with, consulted a medical professional for, been treated for or advised to be treated for:

○ Yes	○ No	Cancer which has spread from the original site or organ
○ Yes	○ No	Hodgkin's Disease
○ Yes	○ No	Lymphoma
○ Yes	○ No	Multiple Myeloma
○ Yes	○ No	Scleroderma
○ Yes	○ No	Systemic Lupus Erythematosus
○ Yes	○ No	Sarcoidosis
○ Yes	○ No	Pulmonary Fibrosis
○ Yes	○ No	Cystic Fibrosis
○ Yes	○ No	Alzheimer's Disease
○ Yes	○ No	Memory Loss
○ Yes	○ No	Senility
○ Yes	○ No	Dementia
○ Yes	○ No	Organic Brain Syndrome
○ Yes	○ No	Schizophrenia
○ Yes	○ No	Psychosis
○ Yes	○ No	More than one stroke/ mini-stroke/or combination of Transient Ischemic Attack (TIA)
○ Yes	○ No	Parkinson's Disease
○ Yes	○ No	Muscular Dystrophy
○ Yes	○ No	Huntington's Chorea
○ Yes	○ No	Motor Neuron Disease
○ Yes	○ No	Lou Gehrig's Disease (ALS)
○ Yes	○ No	Demyelinating Disease
○ Yes	○ No	Multiple Sclerosis
○ Yes	○ No	Myasthenia Gravis
○ Yes	○ No	Transverse Myelitis
○ Yes	○ No	Dialysis (kidney)
○ Yes	○ No	Renal Failure
○ Yes	○ No	Nephritis
○ Yes	○ No	Polycystic Kidney Disease
○ Yes	○ No	Paralysis
○ Yes	○ No	Amputation of more than one limb
○ Yes	○ No	Condition which causes limited motion
○ Yes	○ No	Hepatitis (chronic or active)
○ Yes	○ No	Liver Disease
○ Yes	○ No	Cirrhosis
○ Yes	○ No	Organ Transplant (other than kidney or cornea)
○ Yes	○ No	Chronic Fatigue Syndrome
○ Yes	○ No	Acquired Immune Deficiency Syndrome (AIDS)
○ Yes	○ No	AIDS-related complex
○ Yes	○ No	AIDS-related conditions (tested positive for HIV)

[If you answered "Yes" to any question on this page, we regret that coverage is not available to you.]

Applicant information

1. To facilitate processing, please print clearly and complete all information.

First/Middle initial/Last name:	**Gender:** ○ Male ○ Female
Address:	**Date of birth:**
City/State/ZIP:	**Social Security #:**
Home phone:	**Marital status:** ○ Single ○ Married
Work phone:	(Please check "single" if you are widowed or divorced.)

2. To qualify for a spouse/partner discount, please indicate the following:

○ Yes ○ No Is your spouse/partner applying for coverage?

○ Yes ○ No Does your spouse/partner have a [Short-Term Care policy] with us?

If **"Yes,"** list your spouse's/partner's name: _____

Last four digits of SSN: _____

DOB: _____

Choose a benefit level and options

1. Select an application type:

○ This is a request for a new policy.

○ I currently have a Short-Term Care policy and wish to change my daily benefit amount and/or length of total lifetime benefit.

2. Daily Benefit Amount (DBA):

$ _____ per day (Choose from [$50]–[$400] in [$10] increments.)

3. Total Benefit Period:

○ [90 days (3 months)]

○ [180 days (6 months)]

○ [270 days (9 months)]

○ [365 days (12 months)]

Choose a payment method

1. Select one: (**Please note:** You can save money by paying your premium annually.)

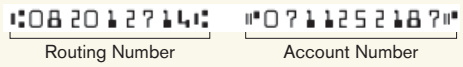
○ **Check/Cash (monthly payment not available)**	**Select frequency:**	**Estimated premium:**
○ **Credit/Debit card:** Please charge my premium.	○ Monthly	_____
Type _____ Account # _____	○ Quarterly	_____
Expiration date _____ Signature _____	○ Semiannually	_____
	○ Annually	_____

○ **Automatic checking account deduction/Electronic funds transfer: Monthly only**

Your monthly premium will be deducted automatically from the bank or credit union checking account you request. **Complete the information below and, if possible, enclose a voided blank check for the account you wish to use.** If using a credit union account, provide credit union phone #: (_____) _____.

Routing Number: _____
(To locate the routing number, simply look at the bottom left-hand corner of the check. The first set of numbers listed is the routing number.)

Account Number: _____
(To locate the account number, look at the bottom of the check, to the right of the routing number.)


Routing Number Account Number

I authorize: (1) UnitedHealthcare to initiate monthly deductions from my checking account, by electronic or other means, as payment for the coverage level selected; and (2) the financial institution on which my designated account is drawn to: (a) accept the deductions initiated by UnitedHealthcare; and (b) give UnitedHealthcare my most recent address upon UnitedHealthcare's request. Deductions will continue until UnitedHealthcare has had a reasonable opportunity to act upon my written request to end this service. I authorize deductions to be taken on the _____ day of the month, or the next business day. If no day is selected, deductions will be taken on the first business day of the month. _____ _____
Signature of account holder for monthly automatic deductions Date

2. Protection against unintended lapse:

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this Short-Term Care insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Would you like to name a person in addition to yourself to receive notice if your coverage is about to lapse due to lack of premium payment?

Please note: This person will **NOT** be responsible for payment of premiums.

○ **Yes** Please provide all information requested.

Full name _____ Relationship _____

Address _____ Telephone (_____)_____

City _____ State _____ ZIP _____

○ **No** **SIGN HERE** IF YOU **REJECT** THIS OFFER _____
Signature of applicant

STEP 3: Read and sign the acknowledgement FOR APPLICANT/PRODUCER 4

Required information: Please check to indicate that you have received the following items.

- ○ **Outline of coverage**
- ○ **Consumer privacy notice**

I represent that all information supplied in this application is true and complete. I understand that, if this is an application for a new policy, UnitedHealthcare will have no liability until a policy is approved and the first full premium is paid. The policy will then be in effect, subject to the terms set forth in the next paragraph. If this is an application for a coverage change, then the coverage change will take effect on the effective date of the change.

I understand that: (1) the policy, if no receipt of premium has been issued; or (2) any coverage change that I am applying for, will not take effect unless on the date the policy is delivered to me or on the date such coverage change would otherwise be effective: (a) the condition of my health is the same as given in this application; and (b) I have not received any medical advice or treatment from a physician or other health care provider since the date of this application. I agree that I will inform UnitedHealthcare if there is a change in my health or if I have received any medical advice or treatment, as described above, between the date of this application and: (1) the date the policy is approved; or (2) the date on which any coverage change is scheduled to go into effect. Wherever my signature appears in this application, it shall have the same force and effect as if I had signed my name in full on the date shown below.

I have read the above answers and statements on this application. I declare that they are true and complete.

Caution: If your answers or statements on this application are incorrect or untrue, UnitedHealthcare may have the right to deny benefits or rescind your policy.

Fraud warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

SIGN HERE _____ _____ _____
Signature of applicant | Printed name of applicant | Date

SIGN HERE _____ _____ _____
Signature of witness (spouse, producer or other) | Printed name of witness (spouse, producer or other) | Date

For producer only

I certify that: (1) the information supplied by the applicant has been truly and accurately recorded on this application: (2) I am not aware of any other information relating to the applicant's health which might have been a bearing on the risk; and (3) the information was taken from the applicant in person.

Signed and dated in: _____ (State) on _____ (Month) _____ (Date), _____ (Year)

SIGN HERE _____
Signature of producer

In connection with my application for a Short-Term Care insurance policy, for underwriting and claim purposes, I authorize:

Any medical practitioner or facility or related entity; any insurer, employer, group policyholder, contract holder or benefit plan administrator to give UnitedHealthcare or any third party acting on UnitedHealthcare's behalf in this regard:

- personal information and data about me from sources including credit reports and motor vehicle history;
- information, records and data about drugs prescribed, medical test results and sexually transmitted diseases, including records from the Medical Information Bureau;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and
- information, records and data about me relating to mental illness, other than psychotherapy notes.

Expiration, revocation and refusal to sign:

This authorization will expire 24 months from the date on this form or sooner if prescribed by law. I understand that, unless permitted by applicable law, I cannot revoke this authorization: (1) to the extent that UnitedHealthcare has taken action relying on the authorization; or (2) if UnitedHealthcare obtained the authorization as a condition to my obtaining insurance coverage. In all other cases, I understand that I may revoke it at any time. To revoke the authorization, I must write to UnitedHealthcare at [PO Box 541203, Waltham, MA 02453-1203] and inform UnitedHealthcare that this authorization is revoked. Any action taken before UnitedHealthcare receives my revocation will be valid. Revocation may be the basis for denying coverage or benefits. If I do not sign this authorization, my application for Short-Term Care insurance cannot be processed.

By signing below, I acknowledge my understanding that:

- All or part of the information, records and data that UnitedHealthcare receives pursuant to this authorization may be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for UnitedHealthcare on the insurance applied for or on existing insurance with UnitedHealthcare, or disclosed as otherwise required or permitted by applicable laws.
- Medical Information Bureau records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans, and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to UnitedHealthcare or upon redisclosure by UnitedHealthcare, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

Please note: A photocopy of this form is as valid as the original form.

SIGN HERE

Signature of applicant	Printed name of applicant	Date
_____	_____	_____

Medical Information Bureau notice: Information regarding your insurability will be treated as confidential. Insurer, or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Health information

1. Primary care physician:

Name:	**Phone:**
Address:	**Date last seen:**
City/State/ZIP:	

2. What is your height? _____

3. What is your weight? _____

4. ○ **Yes** ○ **No** **Have you used any tobacco products (including smoking cessation therapy) in the past 24 months?**

5. ○ **Yes** ○ **No** **Are you covered under Medicaid? ("Medicaid" is different from "Medicare.")**

If you are eligible for or covered by Medicaid, you may not need to purchase the policy since it may provide duplicate benefits.

6. In the past 24 months, have you:

○ Yes ○ No Received treatment in a nursing home, assisted living, rehabilitation or convalescent facility?

○ Yes ○ No Received any type of disability benefit, workers' compensation or Social Security Disability?

○ Yes ○ No Received any home health care, physiotherapy or adult day care services?

○ Yes ○ No Been advised to seek care in a hospital, nursing home, psychiatric facility, assisted living, rehabilitation or convalescent facility or any other health care facility?

If "**Yes**," when and why_____

7. In the past 5 years have you:

○ Yes ○ No Been advised to have any medical testing or surgical procedures that have not been completed or are currently scheduled to be performed?

If "**Yes**," when and why_____

7. Within the past five years (60 months), have you been diagnosed with, consulted a medical professional for, been treated for or advised to be treated for:

○ Yes	○ No	Rheumatoid Arthritis
○ Yes	○ No	Osteoarthritis
○ Yes	○ No	Degenerative Bone Disease
○ Yes	○ No	Degenerative Joint Disease
○ Yes	○ No	Osteoporosis
○ Yes	○ No	Amputation due to disease or medical condition
○ Yes	○ No	Degenerative Disc Disease
○ Yes	○ No	Back condition or surgery
○ Yes	○ No	Neck condition or surgery
○ Yes	○ No	Hip joint condition or surgery
○ Yes	○ No	Knee joint condition or surgery
○ Yes	○ No	Shoulder joint condition or surgery
○ Yes	○ No	Other bone joint condition or surgery
○ Yes	○ No	Amputation
○ Yes	○ No	Ataxia
○ Yes	○ No	Transverse Myelitis
○ Yes	○ No	Myasthenia Gravis
○ Yes	○ No	Post-Polio Syndrome
○ Yes	○ No	Cancer
○ Yes	○ No	Leukemia
○ Yes	○ No	Melanoma
○ Yes	○ No	Tumor
○ Yes	○ No	Anemia
○ Yes	○ No	Platelet Disorder
○ Yes	○ No	Hemophilia
○ Yes	○ No	Hemochromatosis
○ Yes	○ No	Diabetes
○ Yes	○ No	Glucose Metabolism Disorder
○ Yes	○ No	Thyroid problem
○ Yes	○ No	Glandular problem
○ Yes	○ No	Emphysema
○ Yes	○ No	Chronic Bronchitis
○ Yes	○ No	Chronic Obstructive Pulmonary Disease
○ Yes	○ No	Asthma
○ Yes	○ No	Other lung or breathing condition
○ Yes	○ No	Epilepsy
○ Yes	○ No	Seizures
○ Yes	○ No	Convulsions
○ Yes	○ No	Fainting or Falls
○ Yes	○ No	Chronic Fatigue
○ Yes	○ No	Chronic Fatigue Syndrome
○ Yes	○ No	Epstein-Barr Virus
○ Yes	○ No	Fibromyalgia
○ Yes	○ No	Heart Attack
○ Yes	○ No	Heart Surgery
○ Yes	○ No	Chest Pain
○ Yes	○ No	Angina
○ Yes	○ No	Coronary Artery Disease
○ Yes	○ No	Bypass Surgery
○ Yes	○ No	Arrhythmia
○ Yes	○ No	Hypertension
○ Yes	○ No	Palpitations
○ Yes	○ No	Irregular Heartbeat
○ Yes	○ No	Circulatory Disease or surgery
○ Yes	○ No	Vascular Disease or surgery
○ Yes	○ No	Aneurysm
○ Yes	○ No	Carotid Artery Disease or surgery
○ Yes	○ No	Single episode of stroke
○ Yes	○ No	Mini-stroke
○ Yes	○ No	Transient Ischemic Attack (TIA)
○ Yes	○ No	Paralysis
○ Yes	○ No	Blindness
○ Yes	○ No	Numbness
○ Yes	○ No	Tremors
○ Yes	○ No	Imbalance
○ Yes	○ No	Condition causing limited motion
○ Yes	○ No	Mental or nervous disorders
○ Yes	○ No	Psychosis
○ Yes	○ No	Depression
○ Yes	○ No	Anxiety
○ Yes	○ No	Attempted suicide
○ Yes	○ No	Alcohol overuse or abuse
○ Yes	○ No	Drug overuse or abuse
○ Yes	○ No	Bulimia
○ Yes	○ No	Anorexia
○ Yes	○ No	Other eating disorder
○ Yes	○ No	Kidney Disorder
○ Yes	○ No	Prostate Disorder
○ Yes	○ No	Bladder Disorder
○ Yes	○ No	Lupus
○ Yes	○ No	Sarcoidosis
○ Yes	○ No	Bronchiectasis
○ Yes	○ No	Macular Degeneration
○ Yes	○ No	Glaucoma
○ Yes	○ No	Retinitis Pigmentosa
○ Yes	○ No	Any other condition not listed above:

_____

Please note: For any "Yes" answers, give details on page 8.

Treatment information

If you have answered "Yes" to any question(s) on page 7, please provide treatment details below, and any applicable medication details on page 9.

Treating physician:	**Date of diagnosis:**
Condition:	**Date of last symptom:**
Treatment:	**Date last seen:**
Address and phone number of treating physician:	

Treating physician:	**Date of diagnosis:**
Condition:	**Date of last symptom:**
Treatment:	**Date last seen:**
Address and phone number of treating physician:	

Treating physician:	**Date of diagnosis:**
Condition:	**Date of last symptom:**
Treatment:	**Date last seen:**
Address and phone number of treating physician:	

Please use additional pages if you need more room.

Medication information

Please list any medications you have taken during the past 12 months.

Medication:	**Dosage:**
Reason prescribed:	**Frequency:**
Prescribing physician:	

Medication:	**Dosage:**
Reason prescribed:	**Frequency:**
Prescribing physician:	

Medication:	**Dosage:**
Reason prescribed:	**Frequency:**
Prescribing physician:	

○ **Yes** ○ **No** **Other than the information provided previously, have you ever had any symptoms or complaints regarding your health for which you have not yet consulted a physician or received treatment?**

If "**Yes**," what and when _____

To the best of my knowledge and belief, the statements and answers given in this Health Questionnaire are true and complete.

SIGN HERE _____ _____ _____

Signature of applicant | Printed name of applicant | Date

Please use additional pages if you need more room.

Applicant's copy

Received from _____ $_____ on_____
Printed name of applicant Amount Date

IMPORTANT: No coverage will be in effect until your application has been approved by UnitedHealthcare. Please note that receipt of your premium DOES NOT qualify you for coverage.

It is understood and agreed that payment of [two months] premium under this receipt of premium is made and accepted subject to the following conditions:

1. If, after we (UnitedHealthcare) receive: (a) the initial application requirements, as defined below; and (b) evidence of insurability acceptable to us, we determine that as of the date of the application, you are insurable based upon our underwriting criteria and standards for the insurance coverage applied for, the policy will take effect on the date the application was approved by UnitedHealthcare.
2. If we issue a policy to you, any unpaid balance of the full premium due, in accordance with the premium payment mode you have selected, must be paid upon delivery of the policy.

For purposes of this receipt, the initial application requirements are:

1. Completion of the application, in which you have answered "No" to all questions in Step 1 of the application.
2. Completion of an acceptable underwriting assessment, nurse interview, physical examination and assessment, if required by us.
3. Receipt by us of any attending physician statement(s), medical records and any other medical documents that we may require.
4. At least [two months] premium must be submitted in order for this receipt to become effective. The full amount of any check, draft or money order paid under this receipt must be honored on its first presentation for payment.

CAUTION: Your answers to all questions in the eligibility determination are relied upon to accept payment and issue this receipt. If any of these answers are incomplete or incorrect, or UnitedHealthcare is unable to approve the application within 75 days from the date of the application, the amount paid will be returned and this receipt will be null and void from the beginning.

If we determine that as of the date of the application you are not eligible for the insurance coverage applied for, coverage under this receipt will not become effective. There will be no coverage under the receipt of premium and the amount paid will be returned to you.

Limitations on authority: No one but the president, the secretary or a vice president of UnitedHealthcare may change or waive the terms of this receipt of premium. No producer, financial services representative or medical examiner has authority to determine insurability or to make or modify any contract of insurance or waive any of our requirements.

I have read this receipt of premium, and reviewed my answers to all questions in the eligibility determination. I represent that the answers to all those questions are true and complete. I understand and agree that if the answers to any of the questions in the eligibility determination are not true and complete, the amount tendered will be returned and this receipt of premium will be null and void from the beginning. I understand and agree to all of the terms of this receipt of premium. I have received a copy of this receipt of premium.

SIGN HERE _____ _____ _____
Signature of applicant Printed name of applicant Date

No producer or financial services representative is authorized to accept any payment with the application if you answered "Yes" to (or left blank) any of the questions in the eligibility determination.

Receipt of $_____ is acknowledged from _____in connection with the application for Short-Term Care insurance on this date _____.

SIGN HERE _____
Signature of producer

UnitedHealthcare makes no representations as to the tax consequences of the premium paid under this receipt or the benefits you receive under this receipt. Consult your own legal or tax advisor.

Please make all checks payable to [United HealthCare Insurance Company]. Do not make a check payable to the producer or sales representative and do not leave the payee blank.

Producer's copy

Received from _____ $_____ on_____
Printed name of applicant Amount Date

IMPORTANT: No coverage will be in effect until your application has been approved by UnitedHealthcare. Please note that receipt of your premium DOES NOT qualify you for coverage.

It is understood and agreed that payment of [two months] premium under this receipt of premium is made and accepted subject to the following conditions:

1. If, after we (UnitedHealthcare) receive: (a) the initial application requirements, as defined below; and (b) evidence of insurability acceptable to us, we determine that as of the date of the application, you are insurable based upon our underwriting criteria and standards for the insurance coverage applied for, the policy will take effect on the date the application was approved by UnitedHealthcare.
2. If we issue a policy to you, any unpaid balance of the full premium due, in accordance with the premium payment mode you have selected, must be paid upon delivery of the policy.

For purposes of this receipt, the initial application requirements are:

1. Completion of the application, in which you have answered "No" to all questions in Step 1 of the application.
2. Completion of an acceptable underwriting assessment, nurse interview, physical examination and assessment, if required by us.
3. Receipt by us of any attending physician statement(s), medical records and any other medical documents that we may require.
4. At least [two months] premium must be submitted in order for this receipt to become effective. The full amount of any check, draft or money order paid under this receipt must be honored on its first presentation for payment.

CAUTION: Your answers to all questions in the eligibility determination are relied upon to accept payment and issue this receipt. If any of these answers are incomplete or incorrect, or UnitedHealthcare is unable to approve the application within 75 days from the date of the application, the amount paid will be returned and this receipt will be null and void from the beginning.

If we determine that as of the date of the application you are not eligible for the insurance coverage applied for, coverage under this receipt will not become effective. There will be no coverage under the receipt of premium and the amount paid will be returned to you.

Limitations on authority: No one but the president, the secretary or a vice president of UnitedHealthcare may change or waive the terms of this receipt of premium. No producers, financial services representative or medical examiner has authority to determine insurability or to make or modify any contract of insurance or waive any of our requirements.

I have read this receipt of premium, and reviewed my answers to all questions in the eligibility determination. I represent that the answers to all those questions are true and complete. I understand and agree that if the answers to any of the questions in the eligibility determination are not true and complete, the amount tendered will be returned and this receipt of premium will be null and void from the beginning. I understand and agree to all of the terms of this receipt of premium. I have received a copy of this receipt of premium.

SIGN HERE _____ _____ _____
Signature of applicant Printed name of applicant Date

No producer or financial services representative is authorized to accept any payment with the application if you answered "Yes" to (or left blank) any of the questions in the eligibility determination.

Receipt of $_____ is acknowledged from _____in connection with the application for Short-Term Care insurance on this date _____.

SIGN HERE _____
Signature of producer

UnitedHealthcare makes no representations as to the tax consequences of the premium paid under this receipt or the benefits you receive under this receipt. Consult your own legal or tax advisor.

Please make all checks payable to [United HealthCare Insurance Company]. Do not make a check payable to the producer or sales representative and do not leave the payee blank.

STEP 1: Find out if you are eligible to apply

FOR APPLICANT **1**

This step determines your eligibility for coverage under the United HealthCare Insurance Company (UnitedHealthcare) Short-Term Care policy, so please answer all of the questions on this page before completing any other part of this application.

1. Do you currently:

○ Yes	○ No	Use or require the use of any mechanical or medical devices such as a wheelchair, walker, multi-prong cane, crutches, hospital bed, dialysis, respirator oxygen, motorized cart or stair lift?
○ Yes	○ No	Need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, transferring or maintaining continence?
○ Yes	○ No	Need help, assistance or supervision in performing two or more of the following everyday activities: taking medication, doing housework, laundry, shopping or meal preparation?

2. ○ Yes ○ No Within the past two years, has a person or institution acted on your behalf due to any mental or physical disability?

3. Have you ever experienced symptoms of, been diagnosed with, consulted a medical professional for, been treated for or advised to be treated for:

○ Yes	○ No	Cancer which has spread from the original site or organ
○ Yes	○ No	Hodgkin's Disease
○ Yes	○ No	Lymphoma
○ Yes	○ No	Multiple Myeloma
○ Yes	○ No	Scleroderma
○ Yes	○ No	Systemic Lupus Erythematosus
○ Yes	○ No	Sarcoidosis
○ Yes	○ No	Pulmonary Fibrosis
○ Yes	○ No	Cystic Fibrosis
○ Yes	○ No	Alzheimer's Disease
○ Yes	○ No	Memory Loss
○ Yes	○ No	Senility
○ Yes	○ No	Dementia
○ Yes	○ No	Organic Brain Syndrome
○ Yes	○ No	Schizophrenia
○ Yes	○ No	Psychosis
○ Yes	○ No	More than one stroke/ mini-stroke/or combination of Transient Ischemic Attack (TIA)
○ Yes	○ No	Parkinson's Disease
○ Yes	○ No	Muscular Dystrophy
○ Yes	○ No	Huntington's Chorea
○ Yes	○ No	Motor Neuron Disease
○ Yes	○ No	Lou Gehrig's Disease (ALS)
○ Yes	○ No	Demyelinating Disease
○ Yes	○ No	Multiple Sclerosis
○ Yes	○ No	Myasthenia Gravis
○ Yes	○ No	Transverse Myelitis
○ Yes	○ No	Dialysis (kidney)
○ Yes	○ No	Renal Failure
○ Yes	○ No	Nephritis
○ Yes	○ No	Polycystic Kidney Disease
○ Yes	○ No	Paralysis
○ Yes	○ No	Amputation of more than one limb
○ Yes	○ No	Condition which causes limited motion
○ Yes	○ No	Hepatitis (chronic or active)
○ Yes	○ No	Liver Disease
○ Yes	○ No	Cirrhosis
○ Yes	○ No	Organ Transplant (other than kidney or cornea)
○ Yes	○ No	Chronic Fatigue Syndrome
○ Yes	○ No	Acquired Immune Deficiency Syndrome (AIDS)
○ Yes	○ No	AIDS-related complex
○ Yes	○ No	AIDS-related conditions (tested positive for HIV)

[If you answered "Yes" to any question on this page, we regret that coverage is not available to you.]

4. ○ **Yes** ○ **No** **Do you currently use any tobacco products AND have you ever been diagnosed or treated for one of the following conditions: Diabetes, Transient Ischemic Attack (TIA), Stroke, Peripheral Vascular Disease, Chronic Obtrusive Pulmonary Disease, Emphysema, Congestive Heart Failure or Asthma?**

5. ○ **Yes** ○ **No** **Do you have diabetes AND have you ever been diagnosed or treated for any one of the following conditions: Transient Ischemic Attack (TIA), Stroke, Neuropathy, Kidney Disease, Retinopathy or Peripheral Vascular Disease?**

6. ○ **Yes** ○ **No** **Have you been absent from work for more than 10 consecutive days, due to illness, in the past 24 months?**

7. ○ **Yes** ○ **No** **Have you received any type of disability benefit, worker's compensation or Social Security Disability in the past 24 months?**

8. ○ **Yes** ○ **No** **Have you ever been declined or rated for long-term care coverage in the past?**

If "**Yes**," complete information.

Date _____

Reason _____

[If you answered "Yes" to any question on this page, we regret that coverage is not available to you.]

Applicant information

1. To facilitate processing, please print clearly and complete all information.

First/Middle initial/Last name:	**Gender:** ○ Male ○ Female
Address:	**Date of birth:**
City/State/ZIP:	**Social Security #:**
Home phone:	**Marital status:** ○ Single ○ Married
Work phone:	(Please check "single" if you are widowed or divorced.)

2. To qualify for a spouse/partner discount, please indicate the following:

○ Yes ○ No Is your spouse/partner applying for coverage?

○ Yes ○ No Does your spouse/partner have a [Short-Term Care policy] with us?

If **"Yes,"** list your spouse's/partner's name: _____

Last four digits of SSN: _____

DOB: _____

Choose a benefit level and options

1. Select an application type:

○ This is a request for a new policy.

○ I currently have a Short-Term Care policy and wish to change my daily benefit amount and/or length of total lifetime benefit.

2. Daily Benefit Amount (DBA):

$ _____ per day (Choose from [$50]–[$400] in [$10] increments.)

3. Total Benefit Period:

○ [90 days (3 months)]

○ [180 days (6 months)]

○ [270 days (9 months)]

○ [365 days (12 months)]

Choose a payment method

If you are paying premiums yourself, select one of the payment methods listed below in Item # 1. If premiums are employer paid or payroll deducted, skip to Item # 2 - Protection against unintended lapse.

1. Select one: (**Please note:** You can save money by paying your premium annually.)

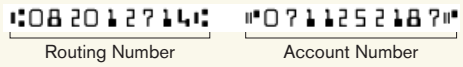
○ **Check/Cash (monthly payment not available)**	**Select frequency:**	**Estimated premium:**
○ **Credit/Debit card:** Please charge my premium.	○ Monthly	_____
Type _____ Account # _____	○ Quarterly	_____
Expiration date _____ Signature _____	○ Semiannually	_____
	○ Annually	_____

○ **Automatic checking account deduction/Electronic funds transfer: Monthly only**

Your monthly premium will be deducted automatically from the bank or credit union checking account you request. **Complete the information below and, if possible, enclose a voided blank check for the account you wish to use.** If using a credit union account, provide credit union phone #: (_____) _____.

Routing Number: _____
(To locate the routing number, simply look at the bottom left-hand corner of the check. The first set of numbers listed is the routing number.)

Account Number: _____
(To locate the account number, look at the bottom of the check, to the right of the routing number.)



Routing Number Account Number

I authorize: (1) UnitedHealthcare to initiate monthly deductions from my checking account, by electronic or other means, as payment for the coverage level selected; and (2) the financial institution on which my designated account is drawn to: (a) accept the deductions initiated by UnitedHealthcare; and (b) give UnitedHealthcare my most recent address upon UnitedHealthcare's request. Deductions will continue until UnitedHealthcare has had a reasonable opportunity to act upon my written request to end this service. I authorize deductions to be taken on the _____ day of the month, or the next business day. If no day is selected, deductions will be taken on the first business day of the month. _____ _____

Signature of account holder for monthly automatic deductions Date

2. Protection against unintended lapse:

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this Short-Term Care insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Would you like to name a person in addition to yourself to receive notice if your coverage is about to lapse due to lack of premium payment?

Please note: This person will **NOT** be responsible for payment of premiums.

○ **Yes** Please provide all information requested.

Full name _____ Relationship _____

Address _____ Telephone (_____)_____

City _____ State _____ ZIP _____

○ **No** **SIGN HERE** IF YOU **REJECT** THIS OFFER _____

Signature of applicant

STEP 3: Read and sign the acknowledgement FOR APPLICANT/PRODUCER 5

Required information: Please check to indicate that you have received the following items.

- ○ **Outline of coverage**
- ○ **Consumer privacy notice**

I represent that all information supplied in this application is true and complete. I understand that, if this is an application for a new policy, UnitedHealthcare will have no liability until a policy is approved and the first full premium is paid. The policy will then be in effect, subject to the terms set forth in the next paragraph. If this is an application for a coverage change, then the coverage change will take effect on the effective date of the change.

I understand that: (1) the policy, if no receipt of premium has been issued; or (2) any coverage change that I am applying for, will not take effect unless on the date the policy is delivered to me or on the date such coverage change would otherwise be effective: (a) the condition of my health is the same as given in this application; and (b) I have not received any medical advice or treatment from a physician or other health care provider since the date of this application. I agree that I will inform UnitedHealthcare if there is a change in my health or if I have received any medical advice or treatment, as described above, between the date of this application and: (1) the date the policy is approved; or (2) the date on which any coverage change is scheduled to go into effect. Wherever my signature appears in this application, it shall have the same force and effect as if I had signed my name in full on the date shown below.

I have read the above answers and statements on this application. I declare that they are true and complete.

Caution: If your answers or statements on this application are incorrect or untrue, UnitedHealthcare may have the right to deny benefits or rescind your policy.

Fraud warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

SIGN HERE _____ Signature of applicant _____ Printed name of applicant _____ Date

SIGN HERE _____ Signature of witness (spouse, producer or other) _____ Printed name of witness (spouse, producer or other) _____ Date

For producer only

I certify that: (1) the information supplied by the applicant has been truly and accurately recorded on this application: (2) I am not aware of any other information relating to the applicant's health which might have been a bearing on the risk; and (3) the information was taken from the applicant in person.

Signed and dated in: _____ State on _____ Month _____ Date , _____ Year

SIGN HERE _____ Signature of producer

In connection with my application for a Short-Term Care insurance policy, for underwriting and claim purposes, I authorize:

Any medical practitioner or facility or related entity; any insurer, employer, group policyholder, contract holder or benefit plan administrator to give UnitedHealthcare or any third party acting on UnitedHealthcare's behalf in this regard:

- personal information and data about me from sources including credit reports and motor vehicle history;
- information, records and data about drugs prescribed, medical test results and sexually transmitted diseases, including records from the Medical Information Bureau;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and
- information, records and data about me relating to mental illness, other than psychotherapy notes.

Expiration, revocation and refusal to sign:

This authorization will expire 24 months from the date on this form or sooner if prescribed by law. I understand that, unless permitted by applicable law, I cannot revoke this authorization: (1) to the extent that UnitedHealthcare has taken action relying on the authorization; or (2) if UnitedHealthcare obtained the authorization as a condition to my obtaining insurance coverage. In all other cases, I understand that I may revoke it at any time. To revoke the authorization, I must write to UnitedHealthcare at [PO Box 541203, Waltham, MA 02453-1203] and inform UnitedHealthcare that this authorization is revoked. Any action taken before UnitedHealthcare receives my revocation will be valid. Revocation may be the basis for denying coverage or benefits. If I do not sign this authorization, my application for Short-Term Care insurance cannot be processed.

By signing below, I acknowledge my understanding that:

- All or part of the information, records and data that UnitedHealthcare receives pursuant to this authorization may be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for UnitedHealthcare on the insurance applied for or on existing insurance with UnitedHealthcare, or disclosed as otherwise required or permitted by applicable laws.
- Medical Information Bureau records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans, and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to UnitedHealthcare or upon redisclosure by UnitedHealthcare, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

Please note: A photocopy of this form is as valid as the original form.

SIGN HERE _____ _____ _____

Signature of applicant | Printed name of applicant | Date

Medical Information Bureau notice: Information regarding your insurability will be treated as confidential. Insurer, or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

SERFF Tracking Number:	*UHLC-125939264*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41080*
Company Tracking Number:			
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.001 Home Health Care*
Product Name:	*UHIC Short Term Care*		
Project Name/Number:	*UHIC Short Term Care/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-125939264*	*State:*	*Arkansas*
Filing Company:	*United HealthCare Insurance Company*	*State Tracking Number:*	*41080*
Company Tracking Number:			
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.001 Home Health Care*
Product Name:	*UHIC Short Term Care*		
Project Name/Number:	*UHIC Short Term Care/*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 12/09/2008

Comments:

Please see the Certification of Readability for this filing. The Consumer Notice is attached to the Forms tab for review and approval.

Attachment:

AR Certification of Readability.pdf

Review Status:

Satisfied -Name: Application 12/09/2008

Comments:

Please refer to the Form tab for the Applications that are being submitted for this filing.

Review Status:

Satisfied -Name: Outline of Coverage 12/09/2008

Comments:

Please refer to the Form tab for the initial submission of this Outline of Coverage.

Certification of Readability

This is to certify that the form listed below is in compliance with recommended insurance policy readability law.

Form STC POL 1000 is to be issued by United Healthcare Insurance Company.

1. The document is printed in not less than ten (10) point type, one (1) point leaded.

2. The layout and spacing of the document separate the paragraphs from each other and from the border of the paper.

3. The section titles are captioned in bold face or otherwise stand out significantly from the text.

4. The document does not use unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions.

5. The style, arrangement and overall appearance of the policy gives no undo prominence to any portion or to any endorsements or riders.

6. A table of contents is included in the policy form.

7. A minimum flesch score of 40.

Signature of Company Officer

Vice President, Compliance
Title

December 10, 2008
Date